REMEDY

Remedy Behavioral Health, LLC
Patient Registration Form

Phone: 888 460 1290 Fax: 256 320 7776 120 South Locust St
Florence AL 35630

First Name: _____ MI: _____ Last Name: _____

DOB: _____ Age: _____ SS#: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone#: _____ Alternate #: _____

Email: _____ Marital Status: _____
May we use the above info to contact you via text ☐Y ☐N Email ☐Y ☐N USPS ☐Y ☐N

Preferred Language: _____ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown or Decline

Race: ☐Caucasian ☐African American ☐Asian ☐American Indian or Alaskan Native ☐Native Hawaiian or Other Pacific Island ☐Other

POA / Guarantor (if patient is less than 18 years old) _____

Primary Care Provider: _____ Preferred Pharmacy: _____

Pharmacy Location / Address: _____

Emergency contact: _____ Phone #: _____

Primary Insurance: _____ Contract #: _____

Subscriber: _____ Relationship to patient: _____ Subscriber DOB: _____

Group#: _____

Secondary Insurance: _____ Contract #: _____

Subscriber: _____ Relationship to patient: _____ Subscriber DOB: _____

Group#: _____

I authorize my insurance benefits be paid directly to the physician. I authorize the release of necessary information to third party payers/insurance companies and pharmacies to process my claims or fill prescriptions. If my insurance denies services, I understand that I will be responsible for any balance. I understand as the patient it is my responsibility to verify my benefits. ***Initial*** _____

I understand and agree that it is my responsibility to know if my insurance has any deductible, copay, co-insurance, out-of-network, visit limit, prior authorization requirements, referral requirements, or any other type of benefits limitation for the services I receive. ***Initial:*** _____

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Insurance Claims and Filing:

Remedy Behavioral Health is committed to providing you with quality care. To achieve this result, we must highlight that as your provider our relationship is with you not your insurance company. While filing insurance claims is a courtesy we extend to all our patients, all charges are ultimately your responsibility. It is your responsibility to know your insurance benefits; please direct any questions concerning your coverage to your insurance company. Proof of current, valid insurance must be provided at time of service. If you do not provide this information, you will be considered a self-pay patient, and will be required to pay the full charge prior to being seen. We participate in most insurance plans however; it is your responsibility to check with your plan prior to your visit to make sure we are participating providers. We will gladly file your claims to your health insurance however, we do not file automobile, general liability, homeowner's, or workman's compensation insurance. ***Initial*** _____

Financial Policies of Remedy Outpatient Clinic:

Please read and review our policies so you will understand office procedures, individual responsibilities, financial liability, and the extent and limits of various forms of communication. These policies may be updated over time for which you will be notified.

Appointments can be requested by telephone, patient portal, or email. Appointments will be confirmed by text/email ahead of time; however, it is the patient's/guardian's responsibility to keep track of the appointments to avoid charges for missed or cancelled appointments. Appointments can be cancelled by the provider if the patient is more than 10 mins late to their appointment. The patient will be subject to full charges. If an appointment is cancelled on same day or missed, the patient/guardian is subject to a no-show fee of $50.00. After 2 missed appointments within 1 calendar year, the patient will be sent a reminder of office policy. After 3 missed appointments within 1 calendar year, the patient could be dismissed from the practice. ***Initial***_____

Payment is due at the time of service. If you are unable to pay your copay, your appointment will be rescheduled and you will be billed a rescheduling fee. Failure to receive your statement does not relieve you of your financial obligations. It is your responsibility to notify us of any changes to your billing information. Past due accounts are subject to our collections process and dismissal as a patient. Other charges are as follows:

Refills: Outside of scheduled appointment	Fee: $25.00	***Initial:***
Appointment No Show and Same Day cancel	Fee: $50.00	***Initial:***
Urine Drug Screen	Fee: $10.00	***Initial:***
NSF Returned Check	Fee: $30.00	***Initial:***

Returned Phone Calls

We will return calls within 48 hours and earlier if possible. Please do not leave a message if you're in an emergency call 988 or 911. See emergency procedures below. Text messaging is ***NOT*** an acceptable form of communication. ***Initial***

_____

If for some reason you cannot reach RBH and patient/guardian deems there is an emergency, they are directed to call 911 or go to nearest emergency room for immediate services. You may also call the National Suicide Hotline at 1 800 273 8255 or 988. ***Initial***_____

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Please allow 24 hours for lab results. Our office will only call you if have abnormal readings. ***Initial*****_____**

Paperwork: charges are based on required time and complexity of completing forms/letters. You may be required to schedule an appointment for completion of forms/paperwork/letters. Office staff will inform you when an appointment is required. ***Initial*****_____**

Medications will be refilled at each appointment if it is clinically appropriate so that patient will not run out before their next appointment. If a patient runs out of medications due to a missed appointment, the non-controlled medications will be refilled one time only (if deemed clinically appropriate by the treating psychiatrist) until next available appointment. The controlled medication(s) will be refilled one time only for up to 30 days (if deemed clinically appropriate by treating psychiatrist) and an appointment must be made within the timeframe to be evaluated in person. Medication refills will not be performed in following cases: after office hours, over the weekend, during holidays, for individuals who repeatedly miss appointments, and if there is suspicion of abuse of medications. ***Initial*****____**

RBH will provide services for Prior Authorizations if needed. Prior authorizations can take up to a week after provider approval to receive an approval or denial for insurance company. Patient is responsible to know if insurance requires a PA. ***Initial*****_____**

Risk of using Email: RBH offers patients the opportunity to communicate via a secure patient portal. We strongly encourage use of the patient portal for communication; however, you may also email RBH at intake@remedybhc.com. Do not send emails to any other email address you may come across. Transmitting patient information by unsecured e-mail has several risks that patients should consider. These include but are not limited to:
E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
E-mail senders can easily misaddress an email. ***Initial*****____**

Notice of Privacy:
I have been offered a copy of my Notice of Privacy Policy and have:
____I declined a copy but am familiar with my rights and understand that I may ask for a copy at any time during my treatment.
___I received a copy of the policy and am aware of my rights.

I, or my authorized representative hereby give consent to Remedy Behavioral Health to take my photograph. I understand this photograph will be stored in the EMR system for identification purposes and protection against insurance fraud.

Consent to provide treatment:
Remedy may provide treatment in the form of medication therapy, psychotherapy, laboratory testing, diagnostic procedures, and other appropriate alternative treatments. You have the right to: be informed of and participate in the section of the treatment methods and plan, receive a copy of this and all consents as well as request your records at any time, or withdraw any consent at any time.

Patient/guardian acknowledgement
I acknowledge that I have read and fully understand RBH *Practice Policies* above.
I acknowledge that I have read and fully understand RBH *Financial Responsibilities, HIPPA Notice of Privacy Practices, and Controlled Substances Agreement* that are available on our website or in office.
I understand the limitations of RBH availability to the client and emergency procedures.

Signature: _____ Date: _____
Print name of person Signing if not the patient: _____ Relationship: _____
Witness Signature: _____ Date: _____

REMEDY

Remedy Behavioral Health, LLC
Medication list

1609 Mockingbird Ct. B
Florence AL 35630

Phone: 888 460 1290

Fax: 256 320 7776

120 South Locust St
Florence AL 35630

Patient Name: _____ DOB_____

Do you give consent to retrieve prescription history? Yes No

Medication	Dose	Directions	Medical Condition

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Controlled Substance Agreement

Controlled substance medications (i.e. benzodiazepines, opioids, amphetamines are very useful, but have a high potential for misuse and are therefore closely controlled by local, state and federal government). As a patient of RBH you agree and understand the following **(initial each section):**

____1. I agree that I will not be prescribed a benzodiazepine from RBH while on an opiate from another provider. If I am on both an opiate and benzodiazepine and would like RBH to prescribe the benzodiazepine, I agree to taper the opiate to discontinuation with the other provider. I agree to sign a release allowing RBH to communicate with the provider prescribing the opiate. If I am prescribed a benzodiazepine from RBH and prefer to be on an opiate from another provider, I agree that RBH will taper my benzodiazepine to discontinuation.

____2. Refills of controlled substance medications will not be made if "I lost my prescription", "ran out early", "misplaced my medication" or "my medication was stolen". I am solely responsible for taking the medication as prescribed and for keeping track of any remaining. Any refills for controlled substance medications that are lost or stolen will be provided at the discretion of the provider.

____3. I understand that if I violate any of the conditions of this contract, my prescriptions for controlled medications may be terminated. If the violation involves obtaining these medications from another individual or the concomitant use of non-prescription illicit (illegal) drugs, I may also be reported to other physicians, pharmacies, medical facilities and the appropriate authorities

____4. I further understand that if I violate this controlled substance contract due to non-compliance of medical directions such as, failure in taking medications as prescribed, utilizing other illicit drugs or abuse of controlled medications, I may be subjected to dismissal from RBH.

____5. I agree to comply with urine drug testing. I understand that my insurance may not cover the cost of the UDS so I will be responsible for the $10.00 UDS fee. If I refuse a requested drug screen, I will not be allowed to see the provider that day and it will result in a same day cancel fee of $50.00.

____6. I agree to keep my scheduled appointments, adhere to the payment policy outlined by the office and conduct myself in a courteous manner while in office.

____7. I agree to not sell, share or give any medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal. I agree to abstain from problematic alcohol usage, opioids, marijuana, cocaine and other addictive substances.

___8. I agree not to obtain medication from any doctors, pharmacies or other sources without telling my treating physician. If I obtain medication from any other prescriber, my prescription for controlled medications may be terminated.

___9. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor. I understand that RBH utilizes the State of Alabama Prescription Drug Monitoring Database and will monitor my prescription history via this source.

I have been fully informed of the above treatment agreement points and have a full understanding of my duties as a patient of RBH in regard to the controlled substance my physician is prescribing.

Patient Signature: _____ Date:

Provider Signature: Date:

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120 South Locust ST
Florence AL 35630

Authorization for the Request of Protected Health Information

This completed form authorizes Remedy Behavioral Health to **request** the following patient information:

Patient's Name: ___ DOB: SS #:

I, the undersigned, authorize _ at Remedy Behavioral Health to request the following **specific** patient information: (check those that apply)

- ☐ Progress notes. Inclusive dates: _____ to _____
- ☐ Copy of outpatient initial assessment
- ☐ Outpatient treatment plan
- ☐ Summary of outpatient treatment to date
- ☐ Summary of psychological evaluation
- ☐ Copy of inpatient H&P
- ☐ Copy of inpatient discharge summary
- ☐ Copy of lab work related to
- ☐ Other: (describe)

- ☐ IOP intake evaluation
- ☐ IOP treatment plan
- ☐ IOP summary of treatment to date
- ☐ IOP discharge plan
- ☐ CD program initial assessment
- ☐ CD program treatment plan
- ☐ CD program discharge summary
- ☐ CD program summary of treatment to date

This information is to be requested from: **(specific name and address)**

This information is to be used for the **specific** purpose(s) of:

This authorization is valid for the period of one year from the date listed below. The patient signature listed below may revoke this authorization at any time and may refuse to sign the authorization. Upon signature, the patient will be provided a copy of this authorization. The information disclosed pursuant to this authorization will not be subject to re-disclosure by the recipient and will be covered by the federal Privacy Rules. The patients' eligibility for benefits, condition of treatment, payment or enrollment in any health plan will not be affected by this authorization. This authorization conforms to 45 CFR – Parts 160 and 164, Dec. 28, 2000.

Patient Signature **Date:**

Parent / Patient Representative Signature **Printed Name and Relationship to Patient** **Date:**

Witness Signature **Date:**

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Authorization for the Release of Protected Health Information

This completed form authorizes and requests Remedy Behavioral Health to **release** the following patient's information:

Patient's Name: _____ DOB: _____ SS#: _____

I, the undersigned, authorize and request Remedy Behavioral Health to release the following **specific** patient information: (include dates of service, type of service, etc.)

☐Initial Evaluation	☐Medication List	☐Drug Screen Results	☐ Appointments
☐Financial Information	☐Lab Results	☐Diagnosis	☐EKG
☐Hospital Discharge Summary	☐Initial Evaluation		☐Drug Screen Results

Other: _____

I understand that this authorization will result in the release of clinical information regarding the patient's diagnosis, behavioral or mental health condition, substance abuse history, and psychiatric and/or counseling services. I understand that these records are strictly confidential and solely for the information of the person to whom addressed.

This information is to be released to: **(specific name and address)** _____

_____

I also authorize RBH to discuss the patient information with the above-named person and/or entity.

This information is to be released for the **specific** purpose(s) of: (if authorization requested by the patient, put "at the request of the individual") _____

_____

This authorization is valid for one year from the date listed below. You may revoke this authorization at any time by notifying RBH in writing, but such revocation will have no effect on disclosures of information already made under this authorization prior to receipt of the revocation. This authorization is voluntary, and you may refuse to sign the authorization and the patients' treatment or payment obligations will not be affected by this authorization unless (i) the treatment is related to research and the use and/or disclosure is related to such research, or (ii) the treatment is solely for the purpose of creating protected health information for disclosure to a third-party. Upon signature you may receive a copy of this authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by state or federal law. RBH will not receive financial or in-kind compensation or remuneration in exchange for the use and/or disclosure of the patient's information unless an applicable legal exception applies. This authorization is continuing in nature and is to be given full force and effect to release any and all of the foregoing information learned or determined after the date hereof until the expiration date. I hold RBH, its employees, directors, officers, agents and representatives harmless from any and all damages which might result to myself, the patient, our representatives, heirs, and/or assigns from the disclosure of this information. A copy or facsimile of this authorization shall be valid and effective, just as the original.

_____ **Date:**
Patient Signature

_____ **Date:**
Parent/Patient Representative Signature (If Applicable) **Printed Name and Relationship to Patient (If Applicable)**

_____ **Date:**
Witness Signature

Patient Name: _____
DOB: _____

Child Patient History Form

Please complete the following and attach additional sheets if needed:

Allergies:	
Current and previous medical history: Add a page if necessary	
Surgical Procedures and dates:	
Mental health hospitalizations (include year and reason):	
Family psychiatric history (list any family member with mental health issues – depression, anxiety, etc.)	
Family history of attempted/completed suicide, relation to patient and date:	

Social History Childhood Family Dynamics:

Who has custody	
A copy of custody papers is required before a child will be seen.	Copies Provided to the office yes: _____ no: _____ Other Comments:

The child is in the household with whom	
How are the members of each household related to the child	

History of Trauma / Abuse

Has the patient ever been in a situation where they feared for their life: Yes No
If yes, explain:

History of Physical Abuse: Yes No
If yes, explain:

History of Physical Abuse: Yes No
If yes, explain:

History of Sexual Abuse: Yes No
If yes, explain:

History of Emotional Abuse: Yes No
If yes, explain:

Has the child been in a severe accident: Yes No
If yes, explain:

Has the patient ever witnessed the death or abuse of another person? Yes No
If yes, explain:

Developmental

Explain any complications during the mother's pregnancy:

Did the mother or father use alcohol, drugs, or tobacco during pregnancy? Yes No
If yes, explain:

Did the mother use prescription drugs during pregnancy? Yes No

If yes, explain:

_____

Did the parents live together during pregnancy? Yes No

How old were the parents when the child was born?

_____

Labor complications?

_____

Birth weight? _____ Premature birth?

_____

Delays in development (ex., Crawling, walking, sentences, social interactions):

_____

School History

Current grade in school? _____ Current grades in school?

_____

Any repeated or failed grades?

_____

Conduct issues?

_____

_____

Special needs "504/IEP":

_____

Describe the child's peer relationships:

_____

Friends/Peer Groups

Does the patient have a boyfriend/girlfriend? _____ Relationship is described as: _____

_____

_____

Is the patient sexually active? _____ History of pregnancy: _____ History of STD:

_____

Tobacco/Drug/Substance Use

Does the patient use any of the following:

Tobacco: Yes No Vape: Yes No

Alcohol: Yes No Street drug use: Yes No

Prescription drug use: Yes No Marijuana use: Yes No

Extracurricular Activities

Is the patient involved in extracurricular activities: Yes No
If yes, explain:

_____

Adolescent Work History

Adolescent work history: Not employed Parttime Fulltime Where:
_____

Legal

Does the patient have a legal and arrest history (if applicable:)
_____
_____
_____
_____
_____

Does the patient have a JPO: Yes No
Court or Drug referral/treatment: Yes No
Suspended/expelled from school: Yes No
is the patient currently in state custody: Yes No

Past mental health treatment/ counseling: Yes NoCurrently Past Previous IOP Drug Court
Mandated Mental Health Treatment Drug Counseling School Counselor Intervention
If any of the above are circled, please explain:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Medicaid Insurance Waiver Form

Remedy Behavioral Health is committed to providing you with quality care. To achieve this result, we must highlight that as your provider our relationship is with you not your insurance company. While filing insurance claims is a courtesy we extend to all our patients, all charges are ultimately your responsibility. It is your responsibility to know your insurance benefits; please direct any questions concerning your coverage to your insurance company. We participate in most of Medicaid's plans however, some plans do not cover all services that we offer for example, some plans do not cover therapist visits. It is your responsibility to know what services you plan does or does not cover. Any services rendered that are not covered by Medicaid are the responsibility of the patient. Medicaid also limits patients 14 office visits a year. If you have reached your office visit limit you will be responsible for any visits going forward. If you have questions about your coverage or visit limit please contact your insurance.

I acknowledge that I have read and fully understand the terms listed above in reference to my Medicaid plan & benefits.

Signature: _____ Date: _____

Print name of person signing if not the patient: _____

Relationship: _____